

of Asian Pacific Islander American, APIA, communities about the devastating impact of HIV/AIDS as well as educating our communities about the progress in the areas of prevention, care and treatment, and vaccines.

Asian Pacific Islander Americans are among the fastest growing racial/ethnic populations in the United States. Despite stereotypes depicting APIAs as “model citizens” who enjoy perfect health, health advocates point out that HIV/AIDS awareness is lacking in many communities. Indeed, APIAs in the U.S. have higher rates of those preventable diseases that are also co-factors for HIV/AIDS—including hepatitis B and tuberculosis—than white Americans.

Worldwide, AIDS has killed more than 20 million people, including 3.1 million in 2004 alone. Through 2003, in the United States, approximately 930,000 people had been diagnosed with AIDS and more than 400,000 people were living with AIDS. While the number of reported AIDS cases among APIAs remains small, lack of detailed HIV surveillance, under-reporting, and misclassification often mask the true impact of the HIV epidemic on APIAs.

Mr. Speaker, according to such groups as the San Francisco-based Asian and Pacific Islander Wellness Center, the Asian Pacific Islander American Health Forum, and the Centers for Disease Control and Prevention, CDC, HIV data collected between 2000–2003 reveals a 54 percent increase in AIDS diagnosis among APIAs. As of December 2003, men accounted for 87 percent of APIA AIDS cases, with 71 percent occurring among men who have same-sex relations. Among APIA women, 49 percent of AIDS cases were attributed to heterosexual contact.

As Chair of the Congressional Asian Pacific American Caucus, I want to say it loud and clear that there is no misunderstanding. HIV/AIDS is a public health emergency for Asian Pacific Islander Americans.

National API HIV/AIDS Awareness Day is the first step in breaking the silence and reducing the shame associated with HIV/AIDS, and I applaud the Banyan Tree Project for their efforts. Reducing stigma will give APIAs greater access to services we need and deserve, which in turn will reduce the spread of HIV.

I urge my colleagues to join me today, along with national, regional, and local HIV/AIDS groups, in supporting this effort to raise awareness of HIV/AIDS among Asians and Pacific Islanders and to mobilize communities to get involved. Only through collaboration and a willingness to break down barriers and build bridges will we be able to win this fight against HIV/AIDS.

THE PRESERVING MEDICARE FOR
ALL ACT OF 2005

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 19, 2005

Mr. CARDIN. Mr. Speaker, I rise to introduce legislation to help fulfill the promise made by Congress and the President to our seniors. This year, Congress may consider a multifaceted approach to programs that affect the security of our seniors. Any discussion about ensuring the financial security of retired

Americans must also take into account their ability to access meaningful prescription drug coverage.

In November 2003, Congress passed legislation to provide limited coverage for prescription drugs. I opposed that legislation because it contained serious flaws that will result in more harm than help for Medicare beneficiaries. The bill that I am introducing today, the Preserving Medicare for All Act of 2005 corrects the legislation's structural defects and provides additional beneficiary protections.

Over the past several years, I have met with thousands of seniors in my district about Medicare and their need for prescription drug coverage. They brought me their empty pill bottles and their pharmacy receipts. With the highest out-of-pocket costs of any age group in the country, they and millions of other seniors across the nation were looking to Congress for real prescription drug coverage that would give them substantial help with their drug costs. They wanted their drug benefit to be provided like other benefits covered by Medicare—administered by the Centers for Medicare and Medicaid Services, CMS, with a guaranteed benefit, universally available regardless of where they live, for it not to jeopardize existing coverage, and yes, they wanted the choice of their own doctor and hospital and the freedom to choose a private health plan if they prefer that option.

I believe that a clear majority of the House and Senate wanted to enact legislation that met our seniors' needs. Unfortunately, the bill that moved through Congress failed to provide seniors with what they needed or expected. The plan that became law will not be administered by CMS but by private insurers.

Under the 2003 law, the government is prohibited from using the purchasing power of 40 million beneficiaries to lower drug prices. There will be no guaranteed benefit, but rather an “actuarially equivalent” benefit whose components insurance companies can manipulate to discourage high-cost seniors from enrolling. It will not be universal, because these insurers can offer different coverage in different areas of the country. It will jeopardize existing coverage: the Congressional Budget Office has estimated that 2.7 million retirees—half of whom have annual incomes of less than \$30,000—will lose the drug benefits they now enjoy as a result of insufficient subsidies to employers. Late last year, 14 months before the drug coverage provisions of the law are to take effect, hundreds of seniors in my district began receiving notices that their employer-based drug coverage would be dropped as their benefits are “coordinated” with Medicare.

Under the guise of “choice” and “competition,” this bill gives billions of extra dollars to managed care plans, which are already reimbursed at rates one-fifth higher than fee-for-service Medicare. This so-called “stabilization fund” and a premium support demonstration project are not designed to offer choice, but instead to lure younger, healthier seniors away from traditional Medicare and into private plans. These features of the bill do not save money, according to the Congressional Budget Office's estimate. Instead, scarce dollars that could be used to provide a better drug benefit are used to increase health plan profits. Those beneficiaries who remain in fee-for-service Medicare will be isolated in an underfunded program and they will see their premiums skyrocket as a result of phony “competition.”

Finally, the new law includes a “cost containment” provision that actually shifts rather than contains costs. By combining the Part A and Part B Trust Funds and creating a new definition of insolvency that caps Medicare's use of general revenues at 45 percent of total Medicare costs, this provision would force government to cut benefits or raise payroll taxes if this limit is exceeded. More than any other element of the new law, this provision would undermine the entire Medicare system as we know it, shifting the burden of the program onto those least able to afford it.

The bill I am introducing today will modify these damaging aspects of the new Medicare law. First it will authorize the HHS Secretary to use the purchasing power of 40 million seniors and disabled Americans to negotiate lower drug prices. Second, it will guarantee seniors the choice of a nationally available, defined benefit within Medicare. The premium, deductible, copays and stoploss will be set by law, not by private insurers. Third, my bill will fully reimburse employers for the cost of qualified retiree drug coverage and it will permit their costs to count toward seniors' catastrophic limits. Fourth, it will repeal the premium support demonstration and help ensure that Medicare remains a national program with equal access for all seniors. Fifth, it will eliminate the “stabilization” fund for private health insurers and dedicate these funds to strengthening the traditional Medicare program for seniors. Finally, it will eliminate the “cost containment” provision of the bill, which will harm both working families, seniors, and health care providers.

Mr. Speaker, the Medicare prescription drug provisions of this bill will not take effect until 2006. We have time to fix the structural problems that prevent this law from benefiting today's beneficiaries and those who will depend on Medicare in future years. If this Congress is serious about the financial security of older Americans, it will make every effort to keep the promises we have made to our seniors. I urge my colleagues to cosponsor this legislation.

LETTER TO SALVADORAN AMBASSADOR TO THE U.S. RENE ANTONIO LEÓN RODRIGUEZ

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 19, 2005

Mr. KUCINICH. Mr. Speaker, on April 29, 2002, Rep. RAÚL GRIJALVA and I sent the following letter to Salvadoran Ambassador to the United States, Rene Antonio León Rodríguez regarding police brutality against Salvadoran government officials:

DEAR AMBASSADOR LEÓN: It has just been brought to our attention that Salvadoran diputados Dr. Salvador Arias and Zoila Quijada were victims of police brutality yesterday while defending protesters of the Social Security Doctors Union (SIMETRISSS).

The protesters were members of the doctors union who were upset about the unjust decision to deport Dr. Pedro Bachon Rodríguez, an Ecuadorian doctor and adviser to the doctors union who has been a legal resident of El Salvador for the past 8 years.